Electronically Delivered

October 3, 2025

Licensee
The Lodge on Summit Oaks
1412 Summit Oaks Drive
Burnsville, MN 55337

RE: Project Number(s) SL30445016

Dear Licensee:

On August 18, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 22, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 22, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 22, 2025, found not corrected at the time of the August 18, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) - $500.00
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3 - $500.00
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5 - $500.00

The details of the violations noted at the time of this follow-up survey completed on August 18, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism

authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. **If you have questions, please contact Jodi Johnson at 507-344-2730.**

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	R 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL33602016-1 On August 18, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 22, 2025. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 340} SS=F	144G.30 Subd. 5 Correction orders	{0 340}		

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{0 340}	Continued From page 1 (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by:	{0 340}	Not reviewed during this survey.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed	{0 480}		

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{0 480}	Continued From page 2 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb	{0 480}		

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{0 480}	Continued From page 3 breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}	Not reviewed during this survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a	{0 780}		

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{0 780}	Continued From page 4 dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	

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{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}		

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{0 810}	Continued From page 6	{0 810}	Not reviewed during this survey.	
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall	{01620}		

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{01620}	Continued From page 7 complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted on September 26, 2024, with diagnoses that included diabetes. R3's service plan dated February 5, 2025,	{01620}		

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{01620}	Continued From page 8 indicated R3 received services to include grooming, dressing, bathing, mobility/positioning, toileting, ambulation assistance, therapeutic exercises, vital signs, dysphagia diet, behavior management, blood sugar checks and medication administration. R3's ongoing nursing assessments dated January 29, 2025, April 28, 2025, and July 30, 2025, were reviewed. The July 30, 2025, assessment was completed 93 days after the date of the previous assessment, thus exceeding 90 calendar days. On August 18, 2025, at 2:05 p.m., clinical nurse supervisor (CNS)-I reviewed R3's assessments and stated the July 30, 2025, assessment was completed late. The licensee's Initial and On-going Assessment of Residents policy dated August 13, 2024, indicated an RN will complete a pre-admission assessment, 14-day assessment: completed up to 14-days after start of service and ongoing assessment: completed periodically but no less than every 90-days. No further information was provided.	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	{01640}		

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{01640}	Continued From page 9 service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for one of two residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R6 was admitted on admitted on March 19, 2025, with diagnoses that included diabetes.	{01640}		

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{01640}	Continued From page 10 R6's service plan dated May 21, 2025, indicated R6 received services to include bathing, grooming, dressing, toileting, transfer assistance, behavior management, monthly vital signs, wound care, blood sugar checks and medication administration. R6's service plan did not include twice daily blood pressure or pulse checks. R6's medication administration record (MAR) dated August 2025, included the following medication: -metoprolol tartrate 50 milligram (mg); give 50 mg two times a day. HOLD if systolic blood pressure (SBP) (the top number in a blood pressure reading) is less than 100 and diastolic blood pressure (DBP) (the bottom number in a blood pressure reading) is less than 60, or pulse is less than 60 R6's signed prescriber orders dated April 1, 2025, included the following medication order: -metoprolol tartrate 50 mg; give one tablet by mouth two times daily. Hold if SBP is less than 100, DBP is less than 60 or pulse is less than 60. On August 18, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-I reviewed R6's service plan and stated it did not include twice daily blood pressure or pulse checks. CNS-I stated she would update the service plan to include blood pressure and pulse checks. The licensee's Contents of Service Plan policy dated October 28, 2024, indicated the following: -all assisted living residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN)/or other licensed health	{01640}		

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{01640}	Continued From page 11 professional. -service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. No further information was provided.	{01640}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	{01940}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01940}	Continued From page 12 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R3 and R6) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3 was admitted on September 26, 2024, with diagnoses that included diabetes. R3's service plan dated February 5, 2025, indicated R3 received services to include grooming, dressing, bathing, mobility/positioning, toileting, ambulation assistance, therapeutic exercises, vital signs, dysphagia diet, behavior management, blood sugar checks and medication administration. R3's Service Recap Summary dated August 2025, included the following: -Accucheck (blood sugar checks) three times a day	{01940}		

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{01940}	Continued From page 13 R3's signed prescriber orders dated April 2, 2025, included the following: -Accucheck three times daily R3's Individualized Treatment and Therapy Plan dated August 11, 2025, listed the following services as treatments: -Therapeutic Exercises -Therapeutic Diet -Transfer Assistance R3's individualized treatment and therapy management plan failed to include the following content: -a statement of the type of services that will be provided (blood sugar checks, weekly vital signs) R6 R6 was admitted on admitted on March 19, 2025, with diagnoses that included diabetes. R6's service plan dated May 21, 2025, indicated R6 received services to include bathing, grooming, dressing, toileting, transfer assistance, behavior management, monthly vital signs, wound care, blood sugar checks and medication administration. R6's service plan did not include daily blood pressure or pulse checks. R6's medication administration record (MAR) dated August 2025, included the following medication: -metoprolol tartrate 50 milligram (mg); give 50 mg two times a day. HOLD if systolic blood pressure (SBP) (the top number in a blood pressure reading) is less than 100 and diastolic blood pressure (DBP) (the bottom number in a blood pressure reading) is less than 60, or pulse is less than 60	{01940}		

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{01940}	Continued From page 14 R6's signed prescriber orders dated April 1, 2025, included the following medication order: -metoprolol tartrate 50 mg; give one tablet by mouth two times daily. Hold if SBP is less than 100, DBP is less than 60 or pulse is less than 60. R6's Individualized Treatment and Therapy Plan dated July 11, 2025, listed the following services as treatments: -Oxygen Assistance -Accucheck (Blood sugar checks) -Wound Care -Continuous glucose monitor R6's individualized treatment and therapy plan failed to include the following required content -a statement of the type of services that will be provided (twice daily blood pressure and pulse checks) On August 18, 2025, at 2:09 p.m., clinical nurse supervisor (CNS)-I reviewed R3 and R6's individualized treatment and management plans and stated they did not include the treatment services as listed above. CNS-I stated she would update R3 and R6's treatment plans to reflect all treatment services being provided. The licensee's Documentation of Medication, Treatments and Therapy Management Services policy dated February 1, 2024, indicated the RN would document the services the resident will receive on the resident's individualized medication management plan and individualized treatment and therapy plan and resident's mediation/treatment record. No further information was provided.	{01940}		

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{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided for one of two residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 was admitted on March 19, 2025, with diagnoses that included diabetes. R6's service plan dated May 21, 2025, indicated R6 received services to include bathing,	{01960}		

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{01960}	Continued From page 16 grooming, dressing, toileting, transfer assistance, behavior management, monthly vital signs, wound care, blood sugar checks and medication administration. R6's service plan did not include daily blood pressure or pulse checks. R6's signed prescriber orders dated April 1, 2025, included the following medication order: -metoprolol tartrate 50 mg; give one tablet by mouth two times daily. Hold if SBP is less than 100, DBP is less than 60 or pulse is less than 60. R6's medication administration record (MAR) dated August 2025, included the following medication: -metoprolol tartrate 50 milligram (mg); give 50 mg two times a day. HOLD if systolic blood pressure (SBP) (the top number in a blood pressure reading) is less than 100 and diastolic blood pressure (DBP) (the bottom number in a blood pressure reading) is less than 60, or pulse is less than 60. R6's record lacked documentation of R6's twice daily blood pressure and pulse checks prior to administering metoprolol tartrate or documentation on why R6's blood pressure and pulse were not taken. On August 18, 2025, at 2:06 p.m., clinical nurse supervisor (CNS)-I reviewed R6's record and stated the staff had not been checking R6's blood pressure or pulse and did not have documentation on why it wasn't checked. CNS-I stated she would add the blood pressure and pulse checks as a separate service to ensure it does not get missed going forward. The licensee's Documentation of Medication,	{01960}		

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{01960}	Continued From page 17 Treatments and Therapy Management Services policy dated February 1, 2024, indicated staff would document each task immediately after that task has been performed in the electronic medical record. No further information was provided.	{01960}		

Electronically Delivered

July 25, 2025

Licensee
The Lodge on Summit Oaks
1412 Summit Oaks Drive
Burnsville, MN 55337

RE: Project Number(s) SL30445016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 22, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30445016-0 On May 19, 2025, through May 22, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 12 residents; 12 receiving services under the Assisted Living Facility license. 0470: On May 20, 2025, an immediate correction order was issued at level 2, Widespread (F). The liecnsee took action on May 20, 2025; however, the scope and level remain at F.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed provide documentation with actions taken to comply with correction orders from a survey completed on November 22, 2022. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 340		

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0 340	Continued From page 2 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ANNUAL FIRE ALARM REPORT During a survey that was conducted November 22, 2022, the licensee was cited using the 0800 tag identification number for failing to provide annual fire alarm report from qualified contractor. On May 21, 2025, survey staff confirmed the deficient condition remained, as the licensee failed to provide annual fire alarm report, and the fire panel now has another trouble. EXHUST FANS: During a survey that was conducted November 22, 2022, the licensee was cited using the 0800 tag identification number for failing to provide covers on exhaust fam in bathroom and laundry room. On May 21, 2025, survey staff confirmed the deficient condition remained as the licensee failed to put exhaust fan covers were missing. FIRE SAFETY AND EVACUATION PLAN: During a survey that was conducted November 22, 2022, the licensee was cited using the 0810 tag identification number for failing to provide a fire safety and evacuation plan (FSEP) that included staff and resident procedures for evacuation, for failing to provide training of staff on the FSEP at time of hire and at least twice per year after, and for failing to offer residents training at least once per year on the FSEP. For failure to show record of fire drills for employees twice per	0 340		

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0 340	Continued From page 3 year, per shift with at least one evacuation drill every other month. On May 21, 2025, survey staff confirmed the deficient condition remained, as the licensee failed to provide a FSEP that included staff and resident procedures for evacuation, for failing to provide training of staff on the FSEP at time of hire and at least twice per year after, and for failing to offer residents training at least once per year on the FSEP. For failure to have record of conduction fire drills for employees twice per year, per shift with at least one evacuation drill every other month. INTERVIEW: The surveyor conducted an interview on May 21, 2025, with maintenance technician (MT)-H stated they didn't know about or have access to any life safety reports. Surveyor then asked assisted living director in residency (ALDIR)-A about the fire alarm report. ALDIR-A was unable to obtain the report and sent information to my e-mail for me to contact alarm company. The surveyor conducted an interview on May 21, 2025, with assisted living director in residency (ALDIR)-A. ALDIR-A provided an electronic version of the FSEP, ALDIR-A stated the FSEP was being printed, but hadn't been picked up yet and not available for staff, residents and visitors. ALDIR-A, stated they didn't have access to the electronic training files and paper copies were at another location. A request was made to have electronic copies sent via e-mail by next morning, no training documents were sent. During interview with ALDIR, they stated that the facility did not attempt a fire evacuation drill in over 2 years.	0 340		

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0 340	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license,	0 420		

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0 420	Continued From page 5 effective April 1, 2025. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the authorized agent on January 27, 2025. As a result of this survey, the following orders were issued under 0470, 0480, 0510, 0550, 0640, 0660, 0680, 0700, 0775, 0780, 0800, 0810, 1060, 1290, 1470, 1530, 1620, 1640, 1710, 1730, 1750, 1880, 1910, 1940, 1960, and 3090, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95.	0 420		

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	30445	A. BUILDING: _____ B. WING _____	05/22/2025

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0 420	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient	0 470	During the course of the survey, the licensee took action to mitigate the	

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0 470	Continued From page 7 staffing to meet the reasonably foreseeable unscheduled needs of one of one resident (R2), who required tracheostomy suctioning (procedure that removes mucus and other secretions from the trachea (windpipe) when a licensed nurse was not onsite/available). This resulted in an immediate correction order issued on May 20, 2025. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 19, 2025, at approximately 9:40 a.m., interim clinical nurse supervisor (ICNS)-C stated the licensee had one resident (R2) with a tracheostomy. R2 was admitted to the licensee on February 20, 2023, with diagnoses that included tracheostomy, dysphagia (difficulty swallowing), and head and neck cancer. R2's service plan dated February 5, 2025, indicated R2 received services to include tracheostomy care. The service plan did not include tracheostomy suctioning. On May 20, 2025, at 9:21 a.m., the surveyor observed suctioning equipment at R2's bedside. At this time the surveyor inquired with unlicensed personnel (ULP)-G if R2 received suctioning	0 470	imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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0 470	Continued From page 8 services. ULP-G stated R2 was independent with suctioning but if he needed help, he would ask for staff assistance. On May 20, 2025, at 9:32 a.m., ICNS-C stated R2 was mostly independent with suctioning but would ask the nurse for help as needed. ICNS-C stated R2 has had an increase in mucus plugs which required more suctioning. ICNS-C stated R2's increase in mucus plugs started when R2 stopped taking his prescribed nebulizer treatments due to concern over cost. ICNS-C stated R2 was admitted to a hospice (end of life care) agency on May 5, 2025. ICNS-C stated the licensee was hopeful that hospice would cover the cost of the nebulizers so R2 would agree to restart nebulizer treatments to help decrease the need for suctioning. ICNS-C stated if a nurse was not onsite or available to suction R2, the staff would call 911. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 27, 2025, indicated the licensee provided tracheostomy suctioning assistance. The UDALSA also indicated the licensee did not have a licensed nurse onsite 24/7. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On May 20, 2025, the licensee implemented actions to mitigate the risk to R2. Scope and severity remain at F.	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 9 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 10 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 11 to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to tube feeding (delivers nutrition directly into the digestive tract through a tube) for the licensees only resident who received tube feedings (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 12 The findings include: On May 20, 2025, at 9:30 a.m., the surveyor observed R2's tube feeding pump. The pump was sticky and had dried brown debris on the monitor and on the pole. The pump had an empty bag hung on it and the tubing was noted to be hanging into a garbage can that had soiled tissues and food in it. The surveyor inquired if R2 used a new bag for each tube feeding. Unlicensed personnel (ULP)-G stated they would rinse out the tube feeding bag daily and reuse it. ULP-G stated sometimes R2 would disconnect this tube feeding once it was completed and he would put the end of the tubing into the garbage in case it leaked. ULP-G left the tubing hanging in the garbage can when she left R2's room. On May 20, 2025, at 10:00 a.m., interim clinical nurse supervisor (ICNS)-C observed R2's tube feeding pump and tubing that was hanging in the garbage can. ICNS-C confirmed the tube feeding pump had built up debris and needed to be cleaned. ICNS-C brought the pump into the bathroom and cleaned it in the shower. ICNS-C replaced the tube feeding bag and tubing. ICNS-C stated she educated the staff on cleaning the pump, and that the tubing should not be hung where it can touch the garbage can. The licensee's Cleaning of Shared Medical Equipment policy dated February 2, 2024, indicated all equipment must be cleaned immediately if visibly soiled, and immediately after use on patients with contact precautions. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 14 The findings include: On May 19, 2025, at 9:57 a.m. during the facility tour, the surveyor did not observe any signage or information posted regarding the grievance procedure, or the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On May 20, 2025, at 1:14 p.m., assisted living director in residency (ALDIR)-A stated the grievance procedure had been posted by the front entrance; however, a resident recently took it down and it had not been reposted yet. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	0 640		

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0 640	Continued From page 15 Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On May 19, 2025, at 9:57 a.m., the surveyor observed the entry and common areas within the facility and noted there was no posting of the information and reporting number for MAARC, as required. On May 20, 2025, at 1:15 p.m., assisted living director in residency (ALDIR)-A stated the MAARC information was not posted. ALDIR-A stated it had been posted by the front entrance; however, a resident recently took it down and it had not been reposted yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 640		

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0 640	Continued From page 16 (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for two of three employees (unlicensed personnel (ULP)-E and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 660		

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0 660	Continued From page 17 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E ULP-E was hired on December 19, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record contained a negative QuantiFERON test dated December 20, 2023; however, ULP-E's employee record lacked evidence of TB history and symptom screening. ULP-G ULP-G was hired on November 28, 2023, to provide direct care and services to the licensee's residents. ULP-G's employee record contained a negative QuantiFERON test dated November 29, 2023; however, ULP-G's employee record lacked evidence of TB history and symptom screening. On May 21, 2025, at 11:17 a.m., assisted living director in residency (ALDIR)-A stated ULP-E and ULP-G's record lacked a TB history and symptom screening. The licensee's TB Plan, Staffing, Education, Monitoring policy dated February 1, 2024, indicated all staff whose essential job functions require work within the same air space of home care residents shall be screened and tested for tuberculosis. No further information was provided.	0 660		

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0 660	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 19 residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 21, 2025, at 9:34 a.m., the surveyor requested to review the licensee's Emergency Preparedness plan. Assisted living director in residency (ALDIR)-A stated the EP Plan was not onsite as they were updating it at the corporate office. ALDIR-A emailed the surveyor the licensee's EP plan. The licensee's undated, Emergency Preparedness plan was reviewed and lacked the following: - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise On May 21, 2024, at 1:20 p.m., ALDIR-A stated	0 680		

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	30445	A. BUILDING: _____ B. WING _____	05/22/2025

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0 680	Continued From page 20 the licensee's current EP plan did not include the above content. The licensee's Emergency and Disaster Preparedness policy dated March 6, 2025, indicated the licensee would be prepared to manage emergency and disaster situations, including missing residents through our hazard assessment and emergency planning. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 700		

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0 700	Continued From page 21 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 19, 2025, at 9:25 a.m. during the entrance conference, interim clinical nurse supervisor (ICNS)-C stated the licensee stored resident's medical records electronically and in paper charts located on the lower level. On May 19, 2025, at 10:05 a.m. during the facility tour with unlicensed personnel (ULP)-D, the surveyor inquired where the residents' medical charts were located. ULP-D opened an unsecured cabinet located in a shared common area on the lower level. The cabinet did not have a way to lock or secure the residents medical charts and was accessible to anyone. On May 21, 2025, at 10:19 a.m., ICNS-C stated she was aware that the resident medical records were stored in an unsecured cabinet that was accessible to unauthorized individuals, including other residents at the facility. ICNS-C stated she was told the licensee used to have a lock on the cabinet, but the key was lost and the lock had not been replaced. ICNS-C stated resident records should be secured and kept private from unauthorized individuals. The licensee's Confidentiality of Resident Records and Information and Access to Records policy dated August 1, 2020, indicated resident records and resident information will be kept confidential unless the resident or the resident's designated representative give permission for release of confidential information.	0 700		

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0 700	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On May 21, 2025, from 2:30 p.m. to 4:30 p.m., the surveyor toured the facility with maintenance technician (MT)-H. During the tour, the surveyor observed: SMOKE ALARMS: Hard-wired smoke alarms in the basement hallway were over 10 years past the manufacturer date. Per MN State Fire Code and manufacturer's	0 775		

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0 775	Continued From page 23 instructions, single- and multiple-station smoke alarms shall be replaced when they exceed ten years from the date of manufacture. All smoke alarms shall be replaced with smoke alarms having the same type of power supply. CIGARETTE BUTT DISPOSAL It was observed that used cigarette butts and ash were being discarded on and around the wooden ramp to the ground below and not in the approved cigarette dispenser located near the dumpster. Used cigarette butts and ashes are required to be dispensed in the approved non-combustible containers. FIRE ALARM REPORT Facility failed to provide the annual fire alarm report. Fire alarm panel had 2 troubles indicated during survey. Fire alarm systems shall be inspected and tested at least annually, the building owner shall be responsible to maintain the fire and life safety systems in an operable condition at all times. CARBON MONOXIDE ALARM Facility has carbon monoxide alarms mounted to the ceilings on upper and lower levels. Alarms could not be tested, and MT-H didn't know anything about them. No proof was provided or testing confirmation that the facility has any working carbon monoxide alarms. Carbon monoxide alarms should be within 10' on the outside of the sleeping room. DRYER DUCT: Lower-level laundry room dryer duct was not connected to vent out dryer exhaust. This allows lint and other combustible material to build up quickly, increasing the risk of fire.	0 775		

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0 775	Continued From page 24 EXTENSION CORDS: In bedroom nine, there was extension cords daisy chained together and being used as permanent source of power. Electrical extension cords are intended for temporary use and not a permanent source of energy. During a facility tour on May 21, 2025, at 3:30 p.m., MT-H, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: INTERCONNECTION On May 21, 2025, from 2:30 p.m. to 4:30 p.m., the surveyor toured the facility with maintenance technician (MT)-H. During the tour, the surveyor observed: Hard-wired smoke alarms in all bedrooms was not interconnected with hard-wired alarms in the upper and lower hallway the facility. Smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility During a facility tour on May 21, 2025, at 3:30 p.m., MT-H, verified the above listed observations	0 780		

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0 780	Continued From page 26 while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On May 21, 2025, from 2:30 p.m. to 4:30 p.m., the surveyor toured the facility with maintenance	0 800		

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0 800	Continued From page 27 technician (MT)-H. The following was observed. WALLS: Lower and upper-level hallways was damaged with scuff, scraps and holes from wheelchair use. DOORS: Several unit doors along both upper and lower hallways were damaged with scuff, scraps and holes from wheelchair use. Unit 7-bedroom door was missing molding around the frame. FLOORS: Kitchen floor has a broken tile near the stove. This has the potential to be a tripping hazard. Laminate flooring near the rear exit was degraded and damaged. This has the potential to be a tripping hazard. CEILING: Lower-level laundry room has two holes in the ceiling reducing the fire separation between the upper and lower levels. Bathroom ceiling vent covers are missing from the lower and upper-level bathrooms. On May 21, 2025, at 3:30 p.m., MT-H, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 28 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and	0 810		

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0 810	Continued From page 29 drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 21, 2025, from 2:30 p.m. to 4:30 p.m., the surveyor toured the facility with maintenance technician (MT)-H., surveyor observed the fire safety and evacuation plan (FSEP) was not located in a central location for staff, residents and visitor accessibility. Facility has gone to paperless and only was able to provide electronic FSEP. Assisted living director in residency (ALDIR)-A stated that FSEP binders were ordered and ready but had not been picked up yet. surveyor observed the posted evacuation plans lacked evacuation routes and only lower level was posted on the upper level. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions for egress in a fire or similar emergency May 21, 2025, from 2:30 p.m. to 4:30 p.m., with ALDIR-A; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire-Code Red",	0 810		

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0 810	Continued From page 30 undated, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On May 21, 2025, at 3:30 p.m., ALDIR-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. ALDIR-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation	0 810		

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0 810	Continued From page 31 plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ALDIR stated training record were not on site and they had no access to provide them during the survey. No other training documentation was provided. On May 21, 2025, at 3:30 p.m., ALDIR-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. ALDIR stated no drills had taken place in the last two years. On May 21, 2025, at 3:30 p.m., ALDIR stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains,	01060		

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01060	Continued From page 32 at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and	01060		

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01060	Continued From page 33 failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 was admitted on August 7, 2024, with diagnoses that included human immunodeficiency virus (HIV) (virus that attacks the body's immune system). R4's progress notes dated March 19, 2025, indicated R4 was sent to the emergency room via emergency medical services (EMS) after R4 was found lying on the floor and complaining of leg pain. R4's progress notes dated March 20, 2025, indicated R4 was admitted to the hospital with a diagnosis of renal abscess. R4's progress notes dated April 4, 2025, indicated R4 was discharged from the hospital to a skilled nursing facility (SNF) for short term rehabilitation. On May 20, 2025, at 7:52 a.m., licensed practical nurse (LPN)-G stated R4 remained at the SNF with an unknown return date to the licensee. LPN-G stated she was not aware of the requirement to provide a written notice for	01060		

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01060	Continued From page 34 emergency relocation and did not notify the Office of Ombudsman for Long-Term Care. R4's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R4's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On May 20, 2025, at 8:26 a.m., assisted living director in residency (ALDIR)-A stated R4's record lacked evidence of a written notice related to R4's emergency relocation had been completed and provided, and further lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21)	01060		

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01060	Continued From page 35 days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility's health facility identification (HFID) number for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01290		

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01290	Continued From page 36 The findings include: ULP-E was hired on December 19, 2023, to provide direct care and services to the residents. ULP-E's employee record contained a Background Study Clearance dated December 18, 2023, from a sister facility. However, the document was not affiliated with the facility's license. The surveyor was provided ULP-E's updated Background Study Clearance dated May 2025, which was completed after the start of survey. On May 21, 2025, at 11:19 a.m., assisted living director in residency (ALDIR)-A stated ULP-E worked as an internal float staff and worked at multiple sister facilities. ALDIR-A stated ULP-E's initial background study was not affiliated with the facility's license. The licensee's Background Checks policy dated September 4, 2024, indicated all employees of the facility with direct resident contact will undergo a background study through DHS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's	01470		

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01470	Continued From page 37 policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01470		

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01470	Continued From page 38 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-E, ULP-G) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E ULP-E was hired on December 19, 2023, to provide direct care and services under the Assisted Living Facility license.	01470		

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01470	Continued From page 39 ULP-E's employee record did not include the following required orientation content: -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of the Human Services, county-managed care advocates, or other relevant advocacy services ULP-G ULP-G was hired on November 28, 2023, to provide direct care and services under the Assisted Living Facility license. ULP-G's employee record did not include the following required orientation content: -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 40 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of the Human Services, county-managed care advocates, or other relevant advocacy services On May 22, 2025, at 9:05 a.m., assisted living director in residency (ALDIR)-A stated ULP-E and ULP-G had not completed all components of the required orientation training as required. The licensee's Assisted Living Orientation policy dated December 30, 2022, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of	01530		

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01530	Continued From page 41 employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-E and ULP-G) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01530		

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01530	Continued From page 42 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee provided services under an Assisted Living Facility license. ULP-E ULP-E was hired on December 19, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record contained evidence the employee received seven hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-G ULP-G was hired on November 28, 2023, to provide direct care and services to the facility's residents. ULP-G's employee record contained evidence the employee received seven hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. On May 21, 2025, at 11:22 a.m., assisted living director in residency (ALDIR)-A reviewed ULP-E and ULP-G's training record and stated they had not completed the required dementia care training as listed above. The licensee's New Employee Orientation Overview dated May 1, 2025, indicated	01530		

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01530	Continued From page 43 employees would complete eight hours of dementia care training within 160 hours worked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620		

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01620	Continued From page 44 licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on March 14, 2022, with diagnoses that included spastic quadriplegia (a permanent neuromuscular disorder that affects all four limbs and the trunk). R1's unsigned, service plan dated May 19, 2025, indicated R1 received services to include bathing assistance, catheter care, dressing, grooming, mobility/positioning, monitor behaviors, physical device-safety check, skin treatment, splint/brace management, toileting, transfer assistance, therapeutic exercises, wound care, vital signs and medication administration. R1's ongoing nursing assessments dated September 1, 2024, December 31, 2024, and March 31, 2025, were reviewed. The December 31, 2024, assessment was completed 121 days after the date of the previous assessment, thus exceeding 90 calendar days. R2	01620		

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01620	Continued From page 45 R2 was admitted on February 20, 2023, with diagnoses that included tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), dysphagia (difficulty swallowing) and head and neck cancer. R2's service plan dated February 5, 2025, indicated R2 received services to include ambulation assistance, bathing, dressing, eating, tube feeding, grooming, manage behaviors, transfer assistance, vital signs, tracheostomy care and medication administration. R2's ongoing nursing assessments dated November 22, 2024, March 12, 2025, and May 5, 2025, were reviewed. The March 12, 2025, assessment was completed 110 days after the date of the previous assessment, thus exceeding 90 calendar days. On May 21, 2025, at 10:28 a.m., interim clinical nurse supervisor (ICNS)-C stated R1 and R2's assessments were not completed within the required time frame. The licensee's Initial and On-going Assessment of Residents policy dated August 13, 2024, indicated an RN will complete a pre-admission assessment, 14-day assessment: completed up to 14-days after start of service and ongoing assessment: completed periodically but no less than every 90-days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01640	Continued From page 46	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01640		

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01640	Continued From page 47 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on March 14, 2022, with diagnoses that included spastic quadriplegia (a permanent neuromuscular disorder that affects all four limbs and the trunk). R1's service plan dated May 19, 2025, indicated R1 received services to include bathing assistance, catheter care, dressing, grooming, mobility/positioning, monitor behaviors, physical device-safety check, skin treatment, splint/brace management, toileting, transfer assistance, therapeutic exercises, wound care, vital signs and medication administration. R1's service plan was not signed by R1 or the licensee. On May 19, 2025, at 1:22 p.m., assisted living director in residency (ALDIR)-A stated R1's service plan was not signed by the licensee or R1. ALDIR-A stated R1 refused to sign any documents without his lawyer present. R2 R2 was admitted on February 20, 2023, with diagnoses that included tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), dysphagia (difficulty swallowing) and head and neck cancer. R2's service plan dated February 5, 2025, indicated R2 received services to include ambulation assistance, bathing, dressing, eating, tube feeding, grooming, manage behaviors,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	05/22/2025

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01640	Continued From page 48 transfer assistance, vital signs, tracheostomy care and medication administration. The service plan did not include tracheostomy suctioning (procedure that removes mucus and other secretions from the trachea). On May 20, 2025, at 9:21 a.m., the surveyor observed suctioning equipment at R2's bedside. At this time, the surveyor inquired with unlicensed personnel (ULP)-G if R2 received suctioning services. ULP-G stated R2 was independent with suctioning but if he needed help, he would ask for staff assistance. On May 20, 2025, at 9:32 a.m., interim clinical nurse supervisor (ICNS)-C stated R2 was mostly independent with suctioning but would ask the nurse for help as needed. ICNS-C stated R2 has had an increase in mucus plugs which required more suctioning. ICNS-C stated R2's increase in mucus plugs started when R2 stopped taking his prescribed nebulizer treatments due to concern over the cost. ICNS-C stated R2 was admitted to a Hospice Agency on May 5, 2025, and were hopeful that hospice would cover the cost of the nebulizers so R2 would agree to restart nebulizer treatments to help decrease the need for suctioning. ICNS-C stated if a nurse was not onsite or available to suction, the staff would call 911. On May 20, 2025, at 9:35 a.m., ICNS-C stated R2's service plan did not include tracheostomy suctioning. ICNS-C stated she would update the service plan to include suctioning services as needed. The licensee's Contents of Service Plan policy dated October 28, 2024, indicated the following: -all assisted living residents would have an	01640		

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01640	Continued From page 49 up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN)/or other licensed health professional. -service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01710		

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01710	Continued From page 50 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on February 20, 2023, with diagnoses that included tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), dysphagia (difficulty swallowing) and head and neck cancer. R2's service plan dated February 5, 2025, indicated R2 received services to include medication administration. R2's comprehensive nursing assessment dated May 5, 2025, indicated staff to administer all medications per written orders from provider. Resident requires assistance with taking all forms of medications due to physical and medical needs. All medications are crushed and mixed with free water and given via g-tube (gastrostomy tube) (feeding tube that provides direct access to the stomach for delivering nutrition, fluids and medications). R2's Individualized Medication Management Plan dated May 5, 2025, indicated the following: -under the section listed as Self-Admin of Meds: Med Self-Admin is not applicable -under the section listed as Medication Administration: staff to administer all medications per written orders from provider. Resident requires assistance with taking all forms of medications due to physical and medical needs. All medications are crushed and mixed with free water and given via g-tube. R2's Medication Administration Record (MAR)	01710		

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01710	Continued From page 51 dated May 2025, included the following medications scheduled at 8:00 a.m.: -furosemide 20 milligrams (mg); one tablet once daily via g-tube (diuretic), prescriber order dated May 15, 2025 -acetaminophen solution 160/5 milliliter (ml); 650 mg via g-tube every six hours (pain), prescriber order dated May 15, 2025 -chest congestion liquid 100/5 ml; 10 ml via g-tube twice daily (chest congestion/mucus), prescriber order dated May 15, 2025 -hydromorphone 4 mg; one tablet via g-tube three times a day (pain), prescriber order dated May 15, 2025 On May 20, 2025, at 9:06 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare R2's 8 a.m., medications. ULP-G placed each medication in a separate medication cup and brought them to R2's room. ULP-G provided R2 with a 60-cc syringe of water. R2 used the syringe of water to flush his g-tube. ULP-G then drew up each medication individually into a syringe and R2 self-administered each medication via his g-tube. ULP-G provided R2 with a 60-cc syringe of water and R2 flushed his g-tube. ULP-G stated R2 self-administers all his medications after the ULP prepare them. On May 21, 2025, at 10:31 a.m., interim clinical nurse supervisor (ICNS)-C stated R2's comprehensive assessment and medication plan indicated staff would administer all medications via g-tube. ICNS-C stated she knew R2 wanted to be as independent as possible with all aspects of his care; however, was not aware that R2 was self-administering medications after the ULP prepared them. ICNS-C stated she would re-assess R2 for appropriateness for self-administration of medications and update his	01710		

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01710	Continued From page 52 services. The licensee's Medication Management Services Provided by Unlicensed Personnel policy dated September 23, 2020, indicated the RN must conduct a face-to face client assessment to determine what medication management services will be provided and how those services will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730		

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01730	Continued From page 53 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 19, 2025,	01730		

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01730	Continued From page 54 at approximately 9:30 a.m., interim clinical nurse supervisor (ICNS)-C stated the licensee provided medication management services to the licensee's residents. R2 was admitted on February 20, 2023, with diagnoses that included tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), dysphagia (difficulty swallowing) and head and neck cancer. R2's service plan dated February 5, 2025, indicated R2 received medication administration. R2's signed prescriber orders dated May 15, 2025, included the following: -acetaminophen PM 25-500 milligrams (mg); one tablet via g-tube (gastrostomy tube) (feeding tube that provides direct access to the stomach for delivering nutrition, fluids and medications). daily at bedtime (sleep) -acetaminophen solution 160/5 milliliters (ml); 650 mg via g-tube every six hours (pain) -aspirin 81 mg; one tablet via g-tube once daily (heart health) -chest congestion liquid 100/5 ml; 10 ml via g-tube twice daily (chest congestion/mucus) -doxazosin 2 mg; one-half tablet via g-tube once daily (heart health) -famotidine 20 mg; one tablet via g-tube twice daily (reflux) -finasteride 5 mg; one tablet via g-tube once daily (prostate) -furosemide 20 mg; one tablet via g-tube once daily (diuretic) -hydromorphone 4 mg; one tablet via g-tube three times daily (pain) -levothyroxine 25 micrograms (mcg); one tablet via g-tube once daily (thyroid)	01730		

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01730	Continued From page 55 -senna 8.6 mg; one tablet via g-tube twice daily (constipation) -trazodone 100 mg; one tablet via g-tube daily at bedtime (sleep) -acetaminophen solution 160/5 ml; 650 mg via g-tube every six hours as needed (pain) -artificial saliva solution; take two sprays by mouth every hour as needed for dry mouth -biotene dry spray moist; two sprays by mouth every one hour as needed (dry mouth) -Carboxymethyl Solution 0.5%; one drop into both eyes daily at bedtime as needed (dry eyes) -diclofenac gel 1%; apply 4 grams topically to legs three times daily as needed (pain) -hydromorphone 4 mg; one tablet via g-tube every four hours as needed for pain -melatonin 3 mg; one tablet via g-tube at bedtime as needed (sleep) -milk of magnesia suspension 1200/15 ml; 30 ml via g-tube daily as needed (constipation) R2's Individualized Medication Management Plan dated May 5, 2025, indicated the following: -under the section listed as Self-Admin of Meds: Med Self-Admin is not applicable -under the section listed as Medication Administration: staff to administer all medications per written orders from provider. Resident requires assistance with taking all forms of medications due t physical and medical needs. All medications are crushed and mixed with free water and given via g-tube. On May 20, 2025, at 9:06 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare R2's 8 a.m., medications. ULP-G placed each medication in a separate medication cup and brought them to R2's room. ULP-G provided R2 with a 60-cc syringe of water. R2 used the syringe of water to flush his g-tube. ULP-G then drew up	01730		

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01730	Continued From page 56 each medication individually in a syringe and R2 self-administered each medication via his g-tube. ULP-G provided R2 with a 60-cc syringe of water and R2 flushed his g-tube. ULP-G stated R2 self-administers all his medications after the ULP prepares them. On May 21, 2025, at 10:31 a.m., ICNS-C reviewed R2's individualized medication management plan stated it did not include self-administration of medications. The licensee's Medication Management Services Provided by Unlicensed Personnel policy dated September 23, 2020, indicated the RN must conduct a face-to face client assessment to determine what medication management services will be provided and how those services will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel	01750		

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01750	Continued From page 57 about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin via a prefilled insulin pen was administered according to manufacturer instructions by one of two unlicensed personnel (ULP-E). The licensee failed to ensure the registered nurse documented resident-specific instructions for one of two residents (R1) whose medication administration was delegated to ULP. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: INSULIN R6 was admitted on March 19, 2025, with diagnoses that included diabetes. R6's service plan dated May 21, 2025, indicated R6 received assistance with medication administration. R6's signed prescriber orders dated March 28, 2025, included the following sliding scale Novolog order: -If blood sugar (BS) 0-149 = no insulin -if BS 150-199 = 3 units -if BS 200-249 = 6 units	01750		

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01750	Continued From page 58 -if BS 250-299 = 9 units -if BS 300-349 = 12 units -if BS 350-399 = 15 units -if BS 400 and over = 18 units and call primary care provider Give subcutaneously with meals. R6's signed prescriber orders dated April 7, 2025, included: -Start Novolog 10 units subcutaneously three times a day with meals (starting set dose in addition to sliding scale Novolog order) On May 19, 2025, at 11:59 a.m., ULP-E obtained R6's Novolog insulin pen and dialed the pen to the prescribed 19 units without priming the pen first. ULP-E then administered the insulin into R6's abdomen. On May 19, 2025, at 12:06 p.m., ULP-E stated she forgot to prime the insulin pen prior to dialing the prescribed dose. On May 21, 2025, at 10:16 a.m., interim clinical nurse supervisor (ICNS)-C stated she expected the ULP to prime the insulin pen with two units prior to dialing the prescribed dose. The manufacturer instructions for use for the Novolog insulin pen dated February 2023, indicated the following: A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. B. Attaching the needle: Remove the protective tab from disposable needle. Screw the needle tightly onto your insulin pen. C. Pull off the big outer needle cap D. Pull off the inner needle cap and throw it away E. Turn the dose selector to select 2 units F. Hold your Novolog pen with the needle pointing	01750		

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01750	Continued From page 59 up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. H. Turn the dose selector to the number of units you need to inject. The pointer should line up with your dose. RESIDENT-SPECIFIC INSTRUCTIONS R1 was admitted on March 14, 2022, with diagnoses that included spastic quadriplegia (a permanent neuromuscular disorder that affects all four limbs and the trunk) R1's service plan dated May 19, 2025, indicated R1 received services to include medication administration. R1's service plan was not signed by R1 or the licensee. R1's signed prescriber orders dated April 4, 2025, included: -senna 8.6 milligrams (mg); take 1-3 tablets orally daily as needed (constipation) -acetaminophen 325 mg; take tow tablets by mouth every 4-6 hours as needed (pain) The licensee failed to have resident-specific instructions regarding when to give one, two, or three tablets of senna and when to give acetaminophen every four hours versus every six hours. On May 21, 2025, at 10:21 a.m., ICNS-C reviewed R1's prescriber orders and stated they	01750		

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01750	Continued From page 60 did not include resident specific directions for the ULP as noted above. ICS-C stated R1's primary care provider would be on site and will have these orders addressed. The license's Medication and Treatment Orders policy dated March 1, 2025, all medication and treatments would have an appropriate prescriber order in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01880		

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	30445	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 61 of the residents). The findings include: On May 19, 2025, at 9:10 a.m., the surveyor observed an unattended medication cart unlocked with the keys sitting on top of the medication cart. On May 20, 2025, at 8:51 a.m., the surveyor observed licensed practical nurse (LPN)-G walk away from the medication cart, leaving the medication cart unattended with the keys in the lock. LPN-G was gone for approximately five minutes. On May 20, 2025, at 10:00 a.m., interim clinical nurse supervisor (ICNS)-C stated the medication cart should be locked when not in use, and the key should never be left in the lock without staff present. The licensee's Storage of Medications policy dated August 1, 2022, indicated the licensee would take all reasonable precautions to eliminate the theft, diversion or misuse of controlled substances and will comply with requirements regarding the safe storage and disposal of these drugs. The RN would develop an individualized medication management plan for the resident that address storage of the resident's medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01910	Continued From page 62	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R5) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	01910		

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01910	Continued From page 63 situation has occurred only occasionally). The findings include: R5 was admitted to the licensee on November 1, 2022, and discharged on February 21, 2025. R5's Medication Administration Record (MAR) dated February 2025, included the following medications: -baclofen 10 milligrams (mg); Take one tablet by mouth three times a day (muscle spasms) -Calcium 600 mg/800 international units (IU); Take one tablet by mouth daily (supplement) -docusate sodium 100 mg; take one capsule orally daily (constipation) -escitalopram 20 mg; take one and one-half tablet orally daily (depression) -fish oil 1,000 mg; take one capsule by mouth daily (supplement) -Polyethylene glycol powder 17 grams (gm); 1 capful to fill line with at least 8 ounces (oz) of liquid daily (constipation) -Sulfa-Trimethoprim 900-160 mg; take one tablet two times a day (antibiotic) -famotidine 20 mg; take one tablet orally two times daily (GI reflux) -gabapentin 400 mg; take one capsule by mouth at bedtime (pain) -guanfacine 3 mg; take one tablet orally at bedtime (attention deficit hyperactivity disorder) -ibuprofen 200 mg; take one tablet by mouth at bedtime (pain) -melatonin 10 mg; take one tablet by mouth at bedtime (sleep) -Montelukast Sodium 10 mg; take one tablet by mouth at bedtime -quetiapine 25 mg; take two tablets orally at bedtime (anxiety/agitation) -trazodone 200 mg; take one tablet by mouth at	01910		

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01910	Continued From page 64 bedtime (sleep) -albuterol Nebulizer 0.083%; inhale one vial per nebulizer every four hours as needed (shortness of breath) -quetiapine 25 mg; take one tablet orally two times daily as needed (anxiety/agitation) -Ventolin HFA inhaler; inhale two puffs into the lungs four times daily as needed (wheezing/shortness of breath/cough) -acetaminophen 325 mg; take one tablet by mouth every six hours as needed (pain) -enema Ready; insert one enema rectally daily as needed (constipation) R5's discharge care plan dated February 21, 2025, indicated medications were sent with R5's family. R5's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On May 21, 2025, at 10:18 a.m., interim clinical nurse supervisor (ICNS)-C stated a disposition of medication document was completed and sent with R5's family member; however, the licensee did not keep a copy for R5's record. The licensee's Disposal or Disposition of Medication policy dated September 23, 2020, indicated staff will document the disposition or disposal of medications in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910		

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01910	Continued From page 65 days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01940		

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01940	Continued From page 66 review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on March 14, 2022, with diagnoses that included spastic quadriplegia (a permanent neuromuscular disorder that affects all four limbs and the trunk). On May 19, 2025, at 10:34 a.m., the surveyor observed R1 sitting outside wearing a PRAFO (pressure reliving ankle foot orthosis) Boots (brace that can help with providing pressure relief at the heel. Maintaining a good position of your foot and ankle). R1's service plan dated May 19, 2025, indicated R1 received services to include bathing assistance, catheter care, dressing, grooming, mobility/positioning, monitor behaviors, physical device-safety check, skin treatment, splint/brace management, toileting, transfer assistance, therapeutic exercises, wound care, vital signs and medication administration. R1's service plan was not signed by R1 or the licensee.	01940		

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01940	Continued From page 67 R1's signed prescriber orders dated April 4, 2025, included: -Skin Treatment; six days a week: Observe, treat and document wound care: Nephrostomy (a tube that lets urine drain from the kidney through an opening in the skin on the back) Insertion site on right side. 1. Remove old dressing 2, Clean around insertion site with wound cleanser 3. Apply new split 4x4 gauze -Skin Treatment; one day a week: Observe, treat and document wound care: Nephrostomy Insertion site on right side. 1. Remove old dressing 2, Clean around insertion site with wound cleanser 3. Apply new split 4x4 gauze -Wound Care (caregiver): six days a week: Coccyx (tailbone) 1. Remove old dressing. Cleanse with vashe solution/wound cleanser then pat dry. 2. Place small piece of Aquacel Ag Advantage over open wound 3. Cover with 4x4 Ztuvit Plus silicone border dressing -Wound Care (caregiver): six days a week: Left IT and Right elbow 1. Remove old dressing. Cleanse with Vashe solution and pat dry 2. Apply thin strip of iodosorb (brown paste) to piece of alginate (gel like dressing). Place iodosorb side of alginate to wound bed 3. Cover with 4x4 Zetuvit Plus silicone border dressing. May secure elbow dressing with additional tape or small compressive sleeve. -Wound Care (nurse): once a week -Splint/Brace Management: Apply and remove PRAFO -Therapeutic Exercises- Range of Motion-daily	01940		

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01940	Continued From page 68 -Catheter Care-Suprapubic: Provide routine catheter care two times per day -Catheter Care (nursing): change suprapubic catheter every two weeks and as needed. Use a 20 FR with a 10-cc balloon. R1's Service Recap Summary dated May 2025, indicated the staff assisted R1 with the following treatments: -Skin Treatment on Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday morning (nephrostomy insertion site on right side) -Skin Treatment on Mondays (nephrostomy insertion site on right side) -Wound Care (caregiver) once daily -Wound Care (Nurse) once a week on Mondays -Splint/Brace Management twice a day (PRAFO Boots) -Therapeutic Exercises-Range of Motion once a day -Catheter Care (nursing) every 14 days -Catheter Care-Suprapubic: Provide routine catheter care two times per day R1's Individualized Treatment and Therapy Plan dated March 26, 2024, listed the following services as treatments: -Mobility/positioning-bed/chair-Assist of two -Transfer Assistance-3 x/day-Mechanical lift -Therapeutic Exercises- Range of Motion R1's individualized treatment and therapy plan failed to include the following required content -a statement of the type of services that will be provided (nephrostomy care, wound care, suprapubic catheter care, PRAFO boots) -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that	01940		

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01940	Continued From page 69 will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2 R2 was admitted on February 20, 2023, with diagnoses that included tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), dysphagia (difficulty swallowing) and head and neck cancer. R2's service plan dated February 5, 2025, indicated R2 received services to include ambulation assistance, bathing, dressing, eating, tube feeding, grooming, manage behaviors, transfer assistance, vital signs, tracheostomy care and medication administration. The service plan did not include tracheostomy suctioning (procedure that removes mucus and other secretions from the trachea). On May 20, 2025, at 9:21 a.m., the surveyor observed suctioning equipment at R2's bedside. At this time the surveyor inquired with unlicensed personnel (ULP)-G if R2 received suctioning services. ULP-G stated R2 was independent with suctioning but if he needed help, he would ask for staff assistance. On May 20, 2025, at 9:32 a.m., interim clinical nurse supervisor (ICNS)-C stated R2 was mostly	01940		

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01940	Continued From page 70 independent with suctioning but would ask the nurse for help as needed. ICNS-C stated R2 has had an increase in mucus plugs which required more suctioning. ICNS-C stated R2's increase in mucus plugs started when R2 stopped taking his prescribed nebulizer treatments due to concern over the cost. ICNS-C stated R2 was admitted to a Hospice Agency on May 5, 2025, and they were hopeful that hospice would cover the cost of the nebulizers so R2 would agree to restart nebulizer treatments to help decrease the need for suctioning. ICNS-C stated if a nurse was not onsite or available to suction, the staff would call 911. R2's signed prescriber order dated February 21, 2025, indicated "Trach suctioning as needed". R2's signed prescriber orders dated May 12, 2025, included: -Tracheostomy- Trach Care (nurse) weekly 1. Remove 4x4 gauze 2. Clean the area around the suction area with saline ONLY (NO soap) 3. Replace the 4x4 gauze 4. Change trach ties- change one side at a time, the other hand should be holding the other side to ensure the trach does not dislodge. Ensure tie is as tight as you can insert one finger in -Tracheostomy- Trach Care (caregiver) daily 1. Remove 4x4 gauze 2. Clean the area around the suction area with saline ONLY (NO soap) 3. Replace the 4x4 gauze 4. Change trach ties- change one side at a time, the other hand should be holding the other side to ensure the trach does not dislodge. Ensure tie is as tight as you can insert one finger in	01940		

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01940	Continued From page 71 -Tube Feeding: Feeding: 1. Fill feeding bag with enteral nutrition formula 2. Attach bag/tubing to enteral feeding pump 3. Pump settings should already be programmed to feeding rate per provider instructions (verify) 4. Prime tubing until feeding drips out of the end of the tubing (no air) 5. Clean the end of the g-tube with alcohol and the end of the feeding tube 6. Securely attached 7. Release clamp if applied and press run on pump -Tube Feeding: Stop Feeding: 1. Turn off pump 2. Remove feeding tube from port 3. Cleanse port site -Tube Feeding: Tube feeding bags are on back order and they need to be reused until supply is replenished. After overnight tube feeding, rinse out bag with warm water and let air dry -Tube Feeding: Cares: Clean around ostomy daily with mild soap and water, apply new 4x4 gauze to site, note any redness, discoloration or drainage. -Tracheostomy-Trach Care (Nurse) PRN R2's Service Recap Summary, dated May 2025, indicated the staff assisted R2 with the following treatments: -Tracheostomy- Trach Care (caregiver); Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday -Tracheostomy- Trach Care (nurse); every Monday -Tracheostomy-Tracy Care (caregiver) daily at bedtime -Tube Feeding; Daily R2's service recap summary did not include tracheostomy suctioning.	01940		

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01940	Continued From page 72 R2's Individualized Treatment and Therapy Plan dated February 24, 2025, listed the following services as treatments: -Ambulation -Assistance -Transfer Assistance -Tube Feeding: Tube feeding bags are on back order and they need to be reused until supply is replenished. After overnight tube feeding, rinse out bag with warm water and let air dry -Tube Feeding: Cares: Clean around ostomy daily with mild soap and water, apply new 4x4 gauze to site, note any redness, discoloration or drainage. -Tube Feeding: Flush g-tube four times a day with 250 milliliters (ml) of free water. This is equal to four 60 ml syringes each flush for hydration. R2's Individualized Treatment and Therapy plan failed to include the following required content -a statement of the type of services that will be provided; (tracheostomy care, tracheostomy suctioning) -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 21, 2025, at 10:23 a.m., ICNS-C reviewed both R1 and R2's medical records and	01940		

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01940	Continued From page 73 stated R1 and R2's record lacked a individualized treatment management plan to include the required content as listed above. ICNS-C stated she did not know how to create a treatment plan for the residents and would only add treatments as a service. The licensee's Documentation of Medication, Treatments and Therapy Management Services policy dated February 1, 2024, indicated the RN would document the services the resident will receive on the resident's individualized medication management plan and individualized treatment and therapy plan and resident's mediation/treatment record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01960		

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THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

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01960	Continued From page 74 licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on February 20, 2023, with diagnoses that included tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), dysphagia (difficulty swallowing) and head and neck cancer. R2's service plan dated February 5, 2025, indicated R2 received services to include ambulation assistance, bathing, dressing, eating, tube feeding, grooming, manage behaviors, transfer assistance, vital signs, tracheostomy care and medication administration. The service plan did not include tracheostomy suctioning (procedure that removes mucus and other secretions from the trachea). R2's signed prescriber order dated February 21, 2025, included trach suctioning as needed. R2's record lacked documentation of tracheostomy suctioning.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 75 On May 21, 2025, at 10:25 a.m., interim clinical nurse supervisor (ICNS)-C stated R2's record lacked documentation of tracheostomy suctioning because it was not listed as a service that could be provided. The licensee's Documentation of Medication, Treatments and Therapy Management Services policy dated February 1, 2024, indicated staff would document each task immediately after that task has been performed in the electronic medical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03090	Continued From page 76 This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: On May 19, 2025, at approximately 9:10 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On May 20, 2025, at 1:15 p.m., assisted living director in residency (ALDIR)-A stated the posting for electronic monitoring had been posted by the front entrance; however, a resident recently took it down. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

The Lodges Company
1412 Summit Oaks Drive
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

License Info

License: HFID 30445

Risk:
License:
Expires on:
CFPM: Ivy Jo L Strube
CFPM #: 115974; Exp: 01/17/2026

Inspection Info

Report Number: F1018251009
Inspection Type: Full - Single
Date: 5/19/2025 Time: 2:39:32 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery:

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: Establishment does not currently have the appropriate test strips for quat sanitizer. Discussed with staff to order correct test strips.
Comply By: 5/22/2025 Originally Issued On: 5/19/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: Hood filter above stove observed to have heavy grease build up. Discussed with staff to have this area cleaned.
Comply By: 5/30/2025 Originally Issued On: 5/19/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11C *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.
COMMENT: Establishment currently does not have a 3 compartment sink or a dishwasher for cleaning and sanitizing dishes. Establishment is currently using a 3 bucket system for washing, rinsing, and sanitizing. Discussed with manager that this system is not approved for long term use and that they will need to install the appropriate sink or dishwasher.
Comply By: 6/27/2025 Originally Issued On: 5/19/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: Large tile in the kitchen flooring at the center of the kitchen is missing. Discussed with staff to have the tile replaced.
Comply By: 6/2/2025 Originally Issued On: 5/19/2025

Food & Beverage General Comment

ESTABLISHMENT IS DOING ALL SAME DAY SERVICE OF FOODS, BUT DOES HAVE A FULLY COMMERCIAL KITCHEN.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN FAIR CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

ESTABLISHMENT HAS A NEEDLE POINT THERMOMETER FOR CHECKING FOOD TEMPERATURES.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED EMPLOYEE ILLNESS

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1018251009 from 5/19/2025

Ivy Jo Strube

Rebecca Prestwood

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

The Lodges Company
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018251009
Inspection Type: Full
Date: 5/19/2025
Time: 2:39:32 PM

Food Temperature: Product/Item/Unit: BEEF**; Temperature Process:** Cold-Holding
Location: Reach-In Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: reach-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

The Lodges Company
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018251009
Inspection Type: Full
Date: 5/19/2025
Time: 2:39:32 PM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Bucket
Location: Dishwashing Area **Equal To** 400 PPM
Comment: Establishment is currently using a 3 bucket system for washing, rinsing, and sanitizing.
Violation Issued?: No